RIte Share Co-Pay Only Provider Enrollment Form

Please note that completing this form is not necessary if you currently have a Rhode Island Medical Assistance number.

Office Address:

Provider/Group Name	**Last Name**	**First Name**	**Middle Initial**	**Title**
	Group Name			
Tax ID Number	**Individual**		**Group**	
Office Address	**Street**			**Suite/Room**
	City		**State**	**ZIP**
	Contact Name		**Title**	**Phone**

Billing/Pay-To Address:

Name	**Last Name**	**First Name**	**Middle Initial**	**Title**
	Institution Name			
Pay to Address	**Street**			**Suite/Room**
	City		**State**	**ZIP**
	Contact Name		**Title**	**Phone**

***Please complete and return a W-9 and Electronic Funds Transfer (EFT) form.**